

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01756

01773

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East c. LENGTH OF STAY IN lb Lifetime d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Samuel Middle Herman Last Boyer		4. DATE OF DEATH Month February Day 10 Year 19 62			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-18-1884	9. AGE (In years last birthday) yrs. 77	IF UNDER 1 YEAR Months 7 Days 10 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Penna R.R. Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Samuel Boyer			
14. MOTHER'S MAIDEN NAME Louise Biddle		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			
16. SOCIAL SECURITY NO. 717-07-5282		INFORMANT Mrs Arthur Cantwell Janney, North East Md			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Arteriosclerotic Heart Disease DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bl. cerebral thrombosis with partial left hemiplegia					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 24 Jan , 1962, to 10 Feb , 1962, that I last saw the deceased alive on 9 Feb , 1962, and that death occurred at 6:00 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Klaus H. Hochner		M.D. North East, Md		DATE SIGNED 2/12/62	
PHYSICIAN'S NAME (Type) Klaus H. Hochner M.D.		ADDRESS (Street, city or town, state)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-14-1962	22c. NAME OF CEMETERY OR CREMATORY Methodist		22d. LOCATION (City, town, or county) (State) North East, Cecil Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant		ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR Charles E. Kline	
DATE FEB 14 '62		24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician. Page 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01774

01757

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Md. b. COUNTY CECIL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. LENGTH OF STAY IN 1b 4 WEEKS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X CHESAPEAKE CITY			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) UNION HOSPITAL				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDNA Middle T. Last BROWN				4. DATE OF DEATH Month FEB. Day 17 Year 1962			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 1, 1894	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months 6 Days 7 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (County & State, or foreign country) PIKE Co. Ky.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MAT MULLINS				14. MOTHER'S MAIDEN NAME MATTIE ROWE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT THELMA A. BROWN - CHES. CITY, Md. Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. } DUE TO (c) Arteriosclerotic cardiovascular disease				INTERVAL BETWEEN ONSET AND DEATH unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes and senile psychosis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Jan. 22 1962		20f. (City or town) Feb. 17 1962 (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 16 1962 to Feb. 17 1962 , that (I) (we) last saw the deceased alive on Feb. 16 1962 , and that death occurred at 4:20a M., from the causes and on the date stated above.							
22a. SIGNATURE S. Ralph Andrews, Jr.				22b. ADDRESS 233 E. Main St., Elkton, Md.			
22c. PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.				22d. ADDRESS 233 E. Main St., Elkton, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/20/62		23c. NAME OF CEMETERY OR CREMATORY BETHEL CEMETERY		23d. LOCATION (City, town or county) (State) NR. CHESAPEAKE CITY, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME				25a. REC'D BY REGISTRAR DATE FEB 20 '62		25b. REGISTRAR'S SIGNATURE Robert S. Kenna	

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FOR STATE
HEALTH DEPT.

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TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01775 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01758											
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Cecil					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit				c. LENGTH OF STAY IN 1b 1 yr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit				d. STREET ADDRESS Rock Run.	
3. NAME OF DECEASED (Type or print) First Rexier Middle T. Last Chinn						4. DATE OF DEATH Month 2 Day 7 Year 19 62					
5. SEX M		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-9-1914		9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Newton Chinn no information						14. MOTHER'S MAIDEN NAME Laura B. Chinn LAURA Bolden					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) yes: Army W.W. 2				16. SOCIAL SECURITY NO.		17. INFORMANT V.A. Records. Perry Point, Md.				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis and Alcoholie. 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE R.C. Dodson						DATE SIGNED 2-7-62					
EXAMINER'S NAME (Type) R.C. Dodson M.D.						DEPUTY MEDICAL EXAMINER Rising Sun, Md.					
22. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF 2/10/62		22c. NAME OF CEMETERY OR CREMATORY Solon		22d. LOCATION (City, town, or country) Middleburg		(State) VA.			
23. FUNERAL DIRECTOR Wilmington, Del. Ford Chase, Md.						24a. REC'D BY REGISTRAR FEB 13 '62		24b. REGISTRAR'S SIGNATURE C. W. L. H. H.			

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W.A. Records, W. E.

W.A. Records, W. E.

1 FOR STATE HEALTH DEPT. TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01776 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01759

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, R.D.2. d. STREET ADDRESS Elkton, R.D.2.		
3. NAME OF DECEASED (Type or print) Ethel Gertrude Christopherson			4. DATE OF DEATH Month 2 Day 4 Year 19 62		
5. SEX F 6. COLOR OR RACE W			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 11-3-1876		
9. AGE (In years last birthday) 85 yrs.			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife Retired Keeping house		
11. BIRTHPLACE (State or foreign country) England			12. CITIZEN OF WHAT COUNTRY? England		
13. FATHER'S NAME James Wheaton			14. MOTHER'S MAIDEN NAME Isabella Allen		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. A6-646-012		
17. INFORMANT Sidney Coleman, Elkton, R.D.Md.			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion and Oedema of lungs (b) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. EXTERNAL CAUSE OF DEATH PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year 19		
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)			21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		
ACTUAL SIGNATURE R.C. Dodson M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2-4-62		
EXAMINER'S NAME (Type) R.C. Dodson M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Rising Sun, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			22b. DATE THEREOF 2-5-62		
22c. NAME OF CEMETERY OR CREMATORY Silver Brook Cemetery			22d. LOCATION (City, town, or country) (State) Wilmington, Del.		
23. FUNERAL DIRECTOR Ralph M Reed, Rising Sun, Md.			24a. REC'D BY REGISTRAR FEB 7 '62 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus		

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S. J. J.

Elston, R.D.

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Isabella Allen

James Whiston

Sidney Coleman, Elston, R.D.S.

11-3-1875

no

Acute coronary occlusion and rupture of heart

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11-3-1875

Elston, R.D.S.

H. J. Johnson, M.D.

Washington, D.C.

Silver Creek Country

Washington, D.C.

CERTIFICATE OF DEATH

Reg. Dist. No. 01760

01777

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 9- Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Erwin First Middle J. Cummings Last		4. DATE OF DEATH February 3, 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1902
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRIVE SALES		10b. KIND OF BUSINESS OR INDUSTRY MILK	
11. BIRTHPLACE (State or foreign country) Kaolia, Pa.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Cummings		14. MOTHER'S MAIDEN NAME Anna Henderickson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 166-12-8405	
17. INFORMANT DOROTHY CUMMINGS		Address ELKTON, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage of Lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma with Metastasis DUE TO (c) Terminal Pneumonia			INTERVAL BETWEEN ONSET AND DEATH 1-Day 10-Months 2-Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/24/1961 to 2/3/1962 that I last saw the deceased alive on 2/3/1962, and that death occurred at 1:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE James L. Johnson M.D.		245 East High Street 1/3/62	
PHYSICIAN'S NAME (Type) James L. Johnson M. D.		Elkton Cecil Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/5/62	22c. NAME OF CEMETERY OR CREMATORY GILPIN MANOR MEM. PARK NR ELKTON, MARYLAND	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS ELKTON, MD		24a. REC'D BY REGISTRAR DATE FEB 6 '62	
PIPPIN FUNERAL HOME		24b. REGISTRAR'S SIGNATURE Arthur S. House	

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

10/10/10

THE NATIONAL ARCHIVES

COLLEGE PARK, MARYLAND

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[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

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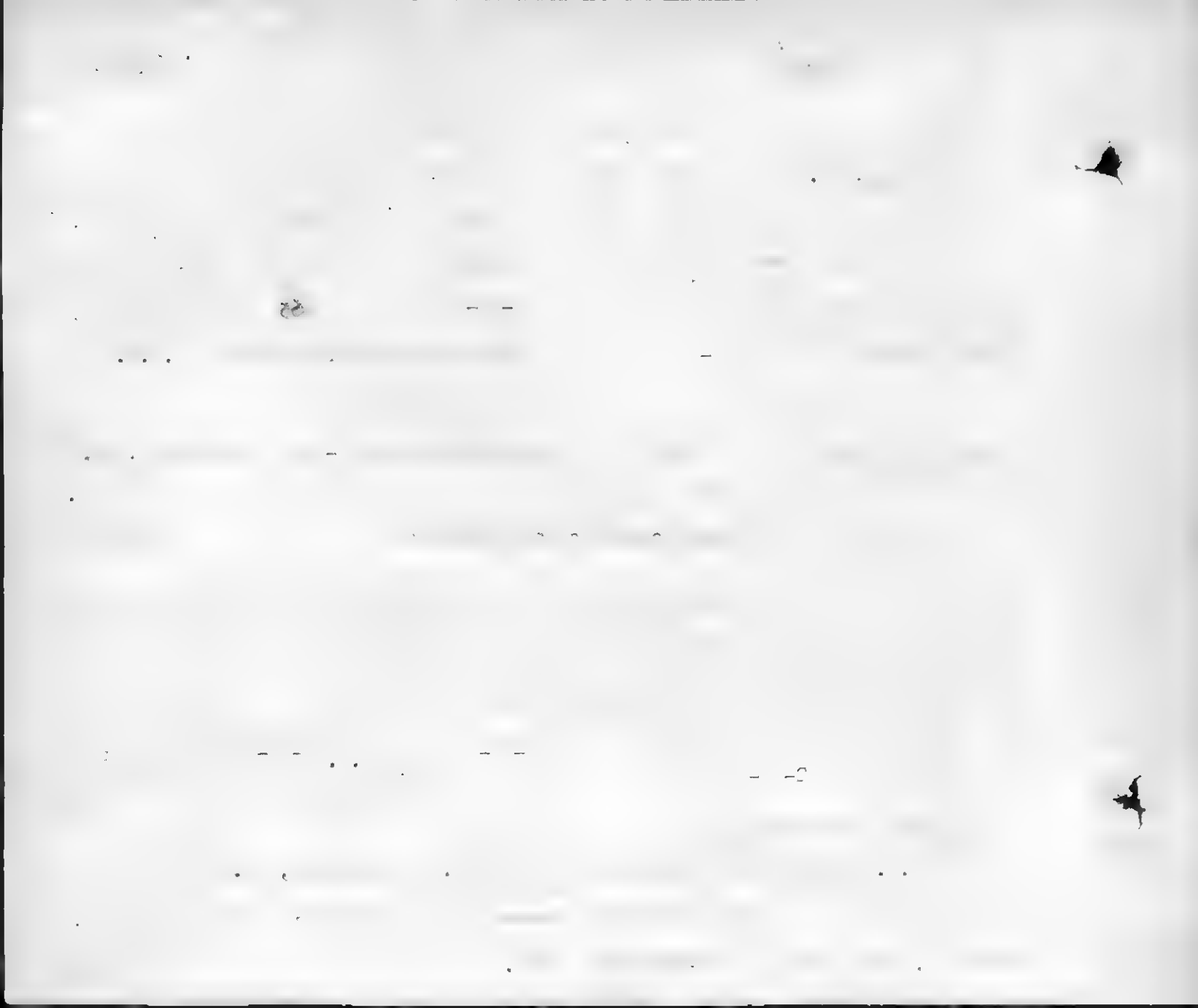
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G306 2/28/62 iwk

01779

CERTIFICATE OF DEATH

Reg. Dist. 01762

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Queen Anne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington Rural 17X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Morgan Nursing Home		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Theresa Middle Felton Last Felton		4. DATE OF DEATH Month February Day 10 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 17, 1881
9. AGE (In years last birthday) 80 yrs.		10. UNDER 1 YEAR Months 1 Days 10 Hours 10 Min 10	11. UNDER 24 HRS. Months 1 Days 10 Hours 10 Min 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frank Felton	
14. MOTHER'S MAIDEN NAME Katherine Litz		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO None		INFORMANT Fred T. Englehardt, 5203 N. Hope St. Phila. 20, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertensive Cardiac Thrombosis DUE TO disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral Arteriosclerosis (c) Chronic Arteritis		INTERVAL BETWEEN ONSET AND DEATH several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Arteritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 30, 1962 to Feb 10, 1962 that I last saw the deceased alive on Jan 30, 1962 and that death occurred at 3:05 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry V. Davis M.D.		ADDRESS (Street, city or town, state) Chesapeake City Md DATE SIGNED 2/10/62	
PHYSICIAN'S NAME (Type) HENRY V. DAVIS MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF February 14, 62	
22c. NAME OF CEMETERY OR CREMATORY Millington Cemetery		22d. LOCATION (City, town, or county) (State) Millington, Kent Co; Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Bellows, Millington, Md.		24a. REC'D BY REGISTRAR FEB 14 '62	
24b. REGISTRAR'S SIGNATURE Arthur S. Thoma			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01780

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01763

1. PLACE OF DEATH a. COUNTY County CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE TENN b. COUNTY CARTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. LENGTH OF STAY IN 1b 2 HRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MOUNTAIN CITY		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) UNION HOSP				d. STREET ADDRESS 322 FRANKLIN ST			
3. NAME OF DECEASED (Type or print) First JUANITA Middle FAYE Last FENNER				4. DATE OF DEATH Month FEB. Day 23 Year 1962			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 6, 1924	9. AGE (In years last birthday) 37 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) TENN.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME OSCAR HOWARD				14. MOTHER'S MAIDEN NAME MAE POTTER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Address DEWEY L. FENNER, HARRISONBURG, Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LACERATION OUTER SIDE LEFT SIDE 6" LONG RIB X DUE TO KNEE 5" LONG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CPD FRACTURE RT. TIBIA & FIBULA & LEFT ELBOW DUE TO FRACTURE AT BASE OF SKULL (c) & LACERATED SCALP							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) HIT BY EARTH REMOVER AT 210N NORTHEAST RD.					
20c. TIME OF INJURY Hour 12:40 a.m. P.M. Month, Day, Year 2/23/62	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) RTE 272	20f. (City or town) 210N	(County) CECIL	(State) MD		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.C. DODSON		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/23/62			
EXAMINER'S NAME (Type) R.C. DODSON		Ma. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/27/62	22c. NAME OF CEMETERY OR CREMATORY PHILIPPI CEM.		22d. LOCATION (City, town, or county) (State) MOUNTAIN CITY, TENN.			
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		ADDRESS ELKTON, MD.		24a. REC'D BY REGISTRAR FEB 26 '62	24b. REGISTRAR'S SIGNATURE J. W. S. HARRIS		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01781 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01764

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Cecil

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

RURAL North East

c. LENGTH OF STAY IN 1b

43 years

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

Maryland

b. COUNTY

Cecil

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

RURAL North East

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

3. NAME OF DECEASED
(Type or print)

First

HOWARD

Middle

I.

FOREAKER

Last

4. DATE OF DEATH

Month

2

Day

17

Year

1962

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

MAY 30, 1905

9. AGE (In years last birthday)

56 yrs.

10. IF UNDER 1 YEAR

Months Days

11. IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Farmer 35 yrs Yard man Bay Boat Yard

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Penna

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Israel Whiteman Foreaker

14. MOTHER'S MAIDEN NAME

Susan Bunce

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

no

16. SOCIAL SECURITY NO.

193-26-4221

17. INFORMANT

Mrs Howard I. Foreaker North East, Maryland

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Acute Coronary Occlusion

INTERVAL BETWEEN ONSET AND DEATH

5 min

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a.

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part I. of item 18)

20c. TIME OF INJURY Month, Day Year
Hour a.m., p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

R.C. Dodson

Rising Sun

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED

2-17-1962

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

2-20-1962

22c. NAME OF CEMETERY OR CREMATORY

Methodist

22d. LOCATION (City, town, or country)

North East, Cecil Co., Md

23. FUNERAL DIRECTOR

Joseph R. Grant North East, Maryland

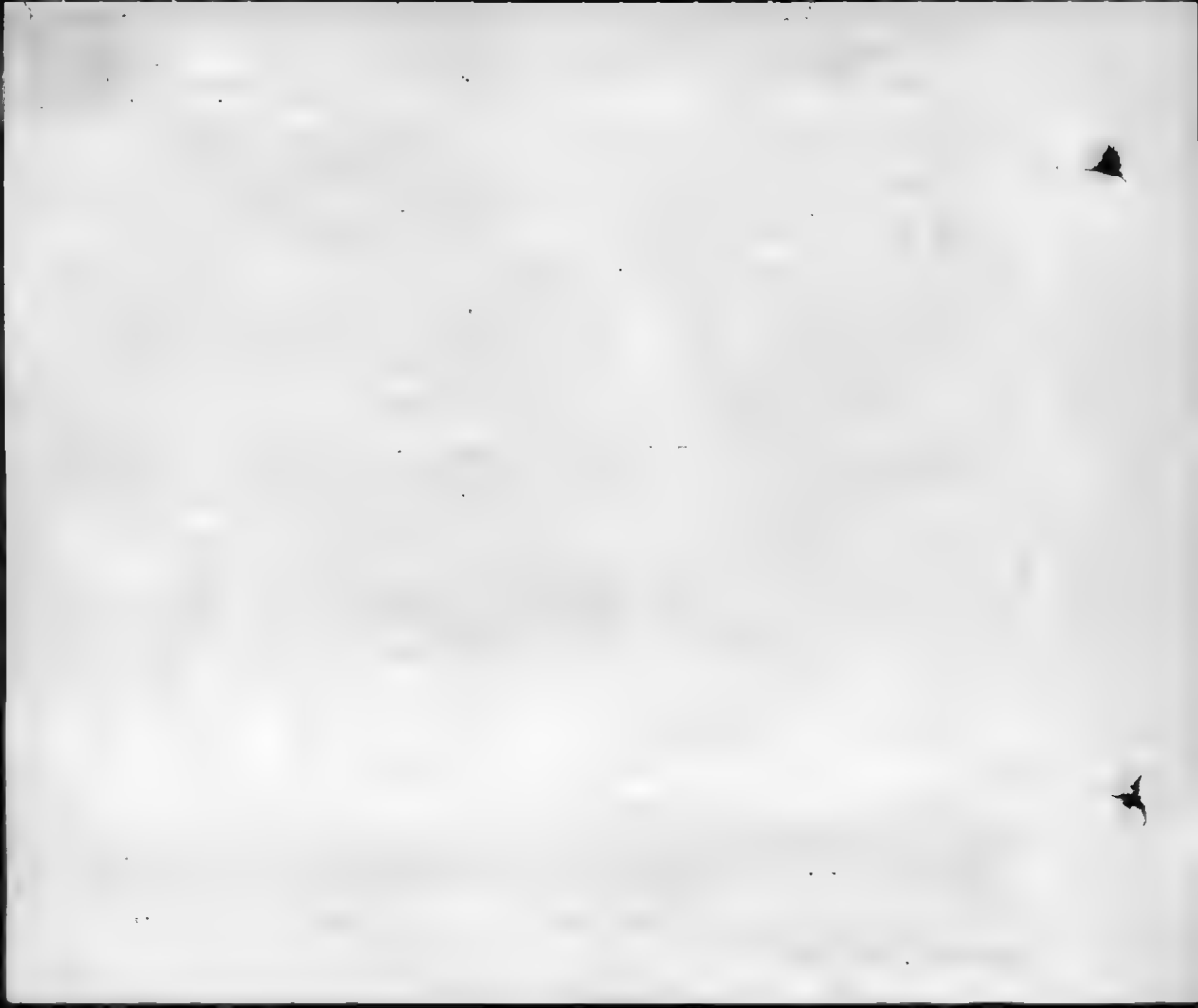
24a. REC'D BY REGISTRAR

DATE FEB 21 '62

24b. REGISTRAR'S SIGNATURE

John S. Thoma

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

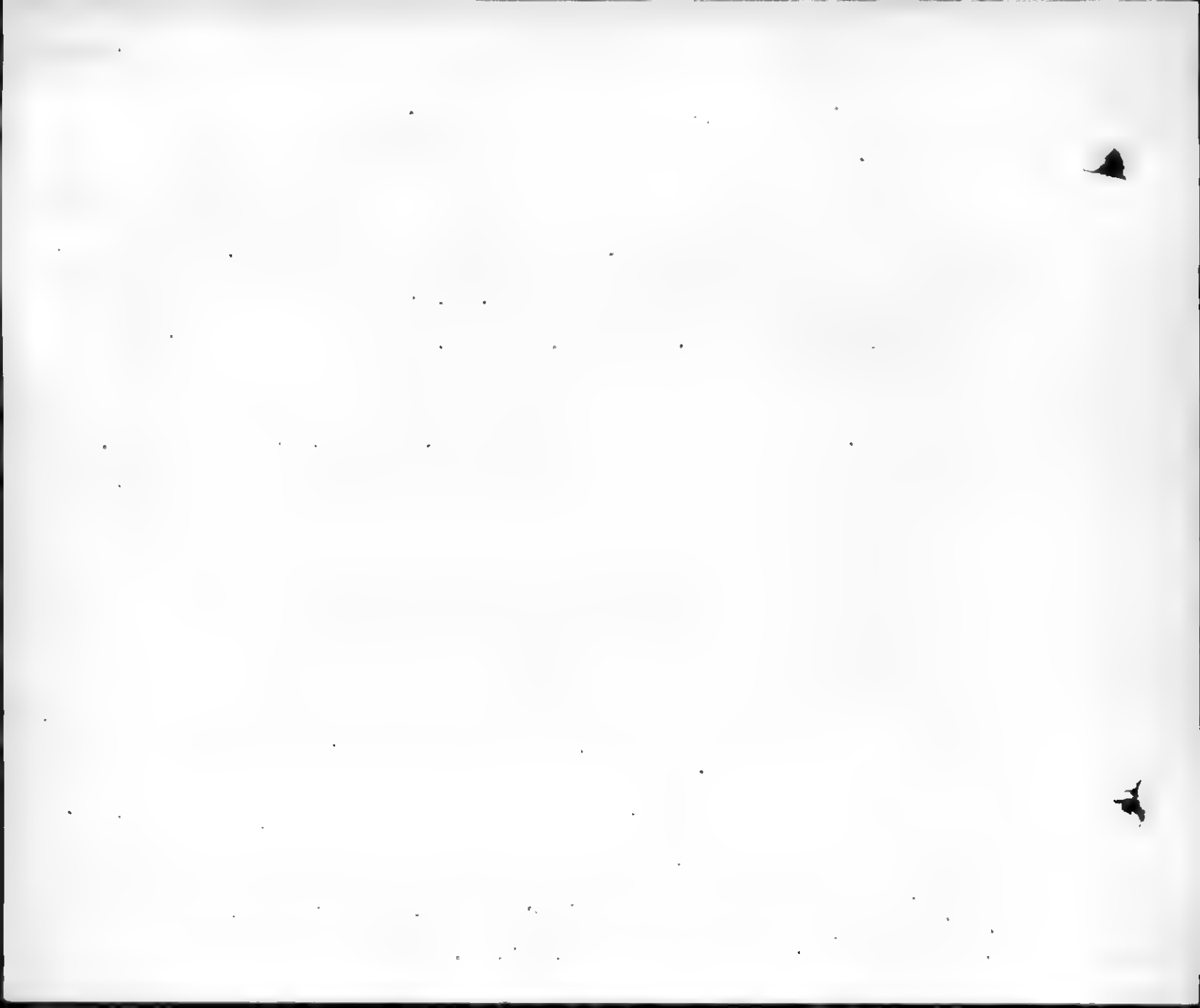
01782

CERTIFICATE OF DEATH

Reg. Dist. No. 01765

1. PLACE OF DEATH o. COUNTY Cecil M		2. USUAL RESIDENCE (Where deceased lived. If institut on: Residence before admission) o. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlestown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First George Middle C. Last Gibson		4. DATE OF DEATH Month Feb. Day 24 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 19, 1890
9. AGE (In years last birthday) 72 yrs		IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min.	IF UNDER 24 HRS Months 72 Days 72 Hours 72 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Mason		10b. KIND OF BUSINESS OR INDUSTRY Pa. Rail Rd.	11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME William Gibson		14. MOTHER'S MAIDEN NAME Lydia Hamilton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 1	
17. INFORMANT Phoebe W. Gibson, Charlestown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 163 X IMMEDIATE CAUSE (a) Carcinoma of lft lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) 1 year DUE TO (c) 1 year		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I (a) B. lateral advanced inactive pulmonary tuberculosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 11202	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that I attended the deceased from 30 April 1961 to 24 Feb 1962 that I last saw the deceased alive on 23 Feb 1962 , and that death occurred at 1:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Klaus H. Huchner		DATE SIGNED 24 Feb '62	
PHYSICIAN'S NAME (Type) Klaus H. Huchner M.D.		ADDRESS (Street, city or town, state) North East Rd	
22a. BURIAL, CREMATION, or other (Specify) Burial	22b. DATE THEREOF 2-27-1962	22c. NAME OF CEMETERY OR CREMATORY West Nottingham Cem.	22d. LOCATION (City, town, or county) (State) Coloma Md. Rural
23. FUNERAL DIRECTOR'S SIGNATURE Rea. Patterson & Son		24a. REC'D BY REGISTRAR Perryville, Md.	
24b. REGISTRAR'S SIGNATURE Chas. J. Hume		DATE FEB 28 '62	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01783 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01786

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun, r.d.		c. LENGTH OF STAY IN Tb 40 yrs.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.		b. COUNTY Cecil		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun, R.D.		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Glen Howard Graybeal		First		Middle		Last		4. DATE OF DEATH Month 2 Day 4 Year 19 62		5. SEX M		6. COLOR OR RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Va.		9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours M'n.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Henry Graybeal		14. MOTHER'S MAIDEN NAME Lidia Cole		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-304-608		17. INFORMANT Mrs. Glen Graybeal, Rising Sun, Md.		Address					
18. CAUSE OF DEATH [Enter on y one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Acute Coronary Occlusion		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 2-4-62.							
ACTUAL SIGNATURE R.C. Dodson		EXAMINER'S NAME (Type) R.C. Dodson, MD.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE OF DEATH Feb 7-1962		22c. NAME OF CEMETERY OR CREMATORY West Nottingham Cc Lora		22d. LOCATION (City, town, or country) Rising Sun, Md.		22e. REC'D BY REGISTRAR Arthur E. McMillen		24b. REGISTRAR'S SIGNATURE Arthur E. McMillen	
23. FUNERAL DIRECTOR Vernon E. McMillen		ADDRESS Rising Sun, Md.		DATE FEB 7 '62											

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01784

CERTIFICATE OF DEATH

Reg. Dist. No.

01767

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		c. LENGTH OF STAY IN 1b Lifetime		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Cheyney Middle Veasey Last Housekeeper			4. DATE OF DEATH Month February Day 10 Year 1962			5. SEX Male		6. COLOR OR RACE White		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-24-1879		9. AGE (In years last birthday) yrs. 82		10. IF UNDER 1 YEAR Months 82 Days 82 Hours 82 Min. 82		11. IF UNDER 24 HRS Months 82 Days 82 Hours 82 Min. 82		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Penna R.R. Telegrapher			10b. KIND OF BUSINESS OR INDUSTRY Telegrapher			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Dr. P.B. Housekeeper				14. MOTHER'S MAIDEN NAME Mary Veasey						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. no			INFORMANT Mrs Roland C. Cain Address North East, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cardio-vascular Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) C.V.A. with cerebral hemorrhage DUE TO (c) Hypertension								INTERVAL BETWEEN ONSET AND DEATH 10 min. 2 Months Years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) I.C.V.D., G.A.S.								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan., 26, 1960 , to Feb., 10, 1962 that I last saw the deceased alive on Feb., 9, 1962 , and that death occurred at 2:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cecil Ave., North East, Md. DATE SIGNED 2-12-62										
ACTUAL SIGNATURE Luis M. Guza M.D.			22a. BUREAU, CREMATION, REMOVAL (Specify) Burial							
PHYSICIAN'S NAME (Type) Luis M. Guza, M.D.			22b. DATE THEREOF 2-13-1962		22c. NAME OF CEMETERY OR CREMATORY St. Mary Anne Episcopal		22d. LOCATION (City, town, or county) (State) North East, Cecil Co., Md			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant			ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR DATE FEB 14 '62		24b. REGISTRAR'S SIGNATURE Joseph R. Grant			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

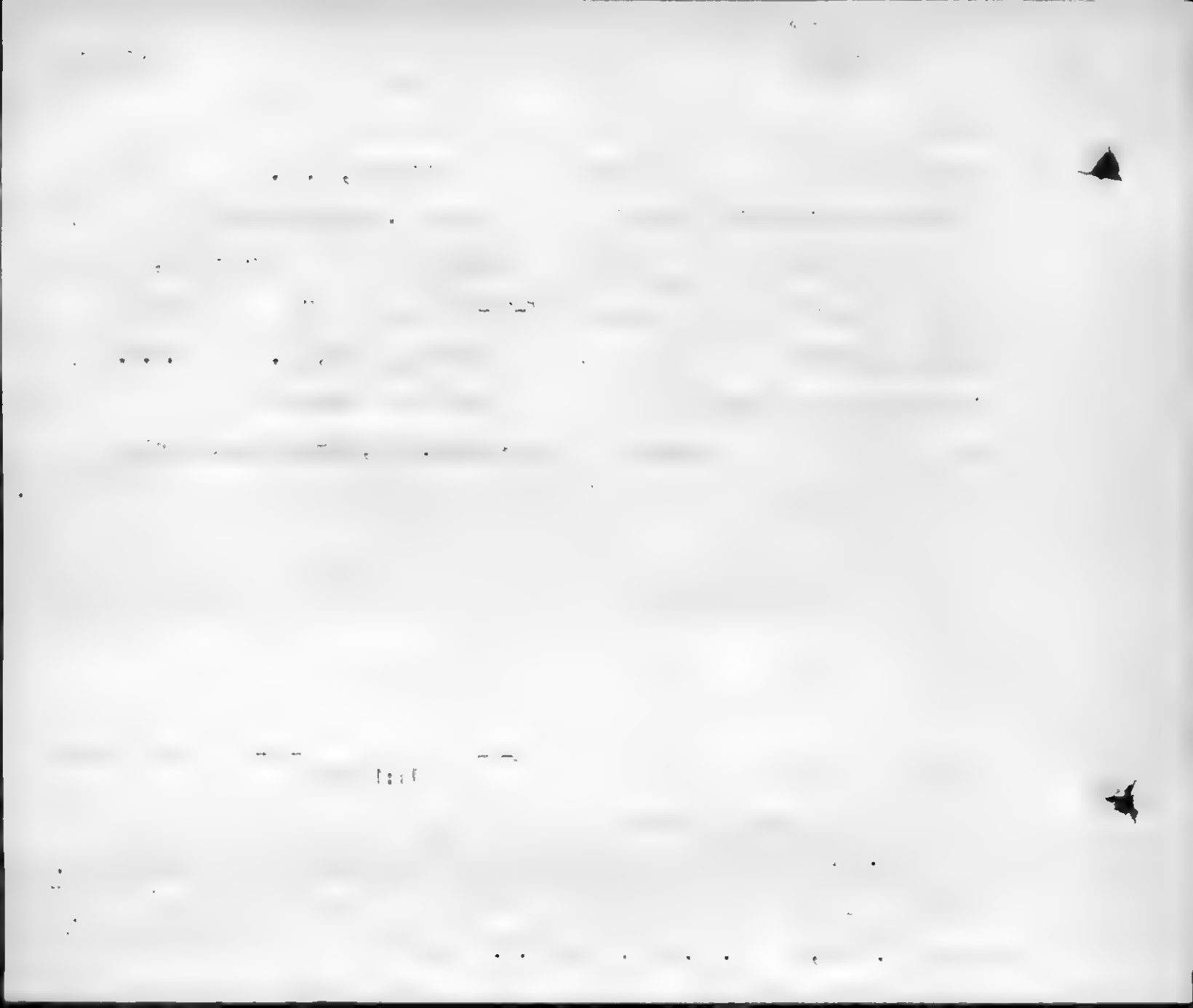


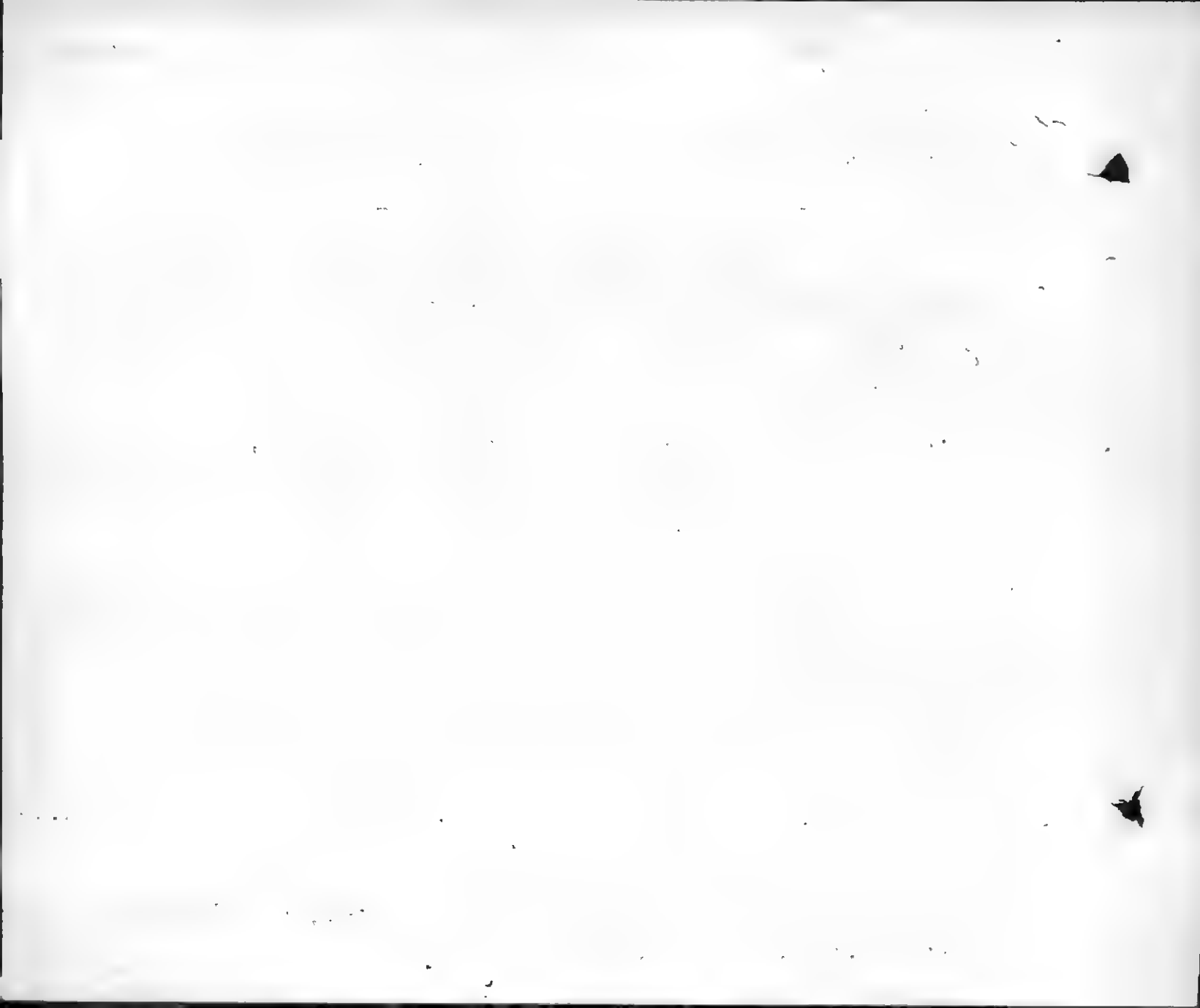
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
TSM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01785 CERTIFICATE OF DEATH 01768

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 25 Days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before adm ssion) a. STATE MARYLAND		b. COUNTY Washington, D. C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.		f. STREET ADDRESS 5106 N. Capitol Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		h. DATE OF DEATH Month February Day 28 Year 19 62	
3. NAME OF DECEASED (Type or print) MASSIE (NMI)		4. DATE OF BIRTH 5-27-88		5. AGE (In years last birthday) 73 yrs.		6. IF UNDER 1 YEAR Months 7 Days 3		7. IF UNDER 24 HRS. Hours 11 M n. 00	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-27-88		9. AGE (In years last birthday) 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Carpentering		11. BIRTHPLACE (County & State, or foreign country) Appomattox City, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Humbles (Deceased)	
14. MOTHER'S MAIDEN NAME Emma Harris (Deceased)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		17. INFORMANT VA Records, VAH, Perry Point, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Uremia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour VA e.m. 19 p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) VA		(County) VA		(State) VA	
21. I certify that Bernard Lin attended the deceased from 2-3-1962 to 2-28-1962 and that death occurred at 11:10PM from the causes and on the date stated above.		22a. SIGNATURE Bernard Lin		22b. DATE SIGNED 3-1-62		22c. PHYSICIAN'S NAME (Type) B. S. LINN		22d. ADDRESS Chief Resident, Surgical Service, VAH, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/5/62		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) Arlington, Virginia		23e. REC'D BY REGISTRAR MAR 7 1962	
24. FUNERAL DIRECTOR'S SIGNATURE Horton Fun.Home, 1322 U.St., N.W.Wash. D.C.		24b. ADDRESS Horton Fun.Home, 1322 U.St., N.W.Wash. D.C.		24c. REGISTRAR'S SIGNATURE William S. Finner		24d. DATE MAR 7 1962		24e. REGISTRAR'S SIGNATURE William S. Finner	





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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01787

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01770

1. PLACE OF DEATH a. COUNTY Cecil				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md.				b. COUNTY Cecil					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit R.D.				c. LENGTH OF STAY IN IL all life				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, R.D.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Emil Thomas Kelley				4. DATE OF DEATH Month 2 Day 2 Year 1962									
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-9-1893		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (G vs kind of work done during most of working life, even if retired) Fireman				10b. KIND OF BUSINESS OR INDUSTRY Boiler				11. BIRTHPLACE (State or foreign country) Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME Fannie Kelley									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. 212-20-0125		17. INFORMANT Helen Evans, Rising Sun, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary occlusion and Chronic Tuberculosis 008.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I												INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE R.C. Dodson				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 2-3-62	
EXAMINER'S NAME (Type) R.C. Dodson M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Rising Sun, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2-6-62		22c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery		22d. LOCATION (City, town, or country) Port Deposit, Md.		(State)			
23. FUNERAL DIRECTOR Ralph M Reed				ADDRESS Rising Sun, Md.				24a. REC'D BY REGISTRAR DATE FEB 8 '62		24b. REGISTRAR'S SIGNATURE Charles S. Evans			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician, and the attending physician and completely filled out by the funeral director. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01788

01771

1. PLACE OF DEATH a. COUNTY CECIL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON c. LENGTH OF STAY IN 1b 17 YRS. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) UNION HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ELKTON d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LAWRENCE FREDERICK KUSZMAUL First Middle Last		4. DATE OF DEATH FEBRUARY 3 1962 Month Day Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 8, 1889
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOAT YARD OWNER		10b. KIND OF BUSINESS OR INDUSTRY BOATS	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME W. F. KUSZMAUL		14. MOTHER'S MAIDEN NAME MINNIE WIGART	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WW I		16. SOCIAL SECURITY NO. 197-18-2974	
17. INFORMANT MRS. SARA KUSZMAUL		Address NR. ELKTON, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (b) 33 X DUE TO Pneumonia and atelectasis of rt lung (c) 33 X DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN DEATH AND DATE OF DEATH 66 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 28 62 to Feb. 3 62 , that (I) (we) last saw the deceased alive on Feb. 2 62 at 12:50 a.m. , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE S. Ralph Andrews, Jr.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.		22d. ADDRESS 233 E. Main St., Elkton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/7/62	
23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d. LOCATION (City, town or county) (State) ARLINGTON, VIRGINIA	
24. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		25a. REC'D BY REGISTRAR FEB 6 '62	
ADDRESS ELKTON, MD.		25b. REGISTRAR'S SIGNATURE C. S. Kline	

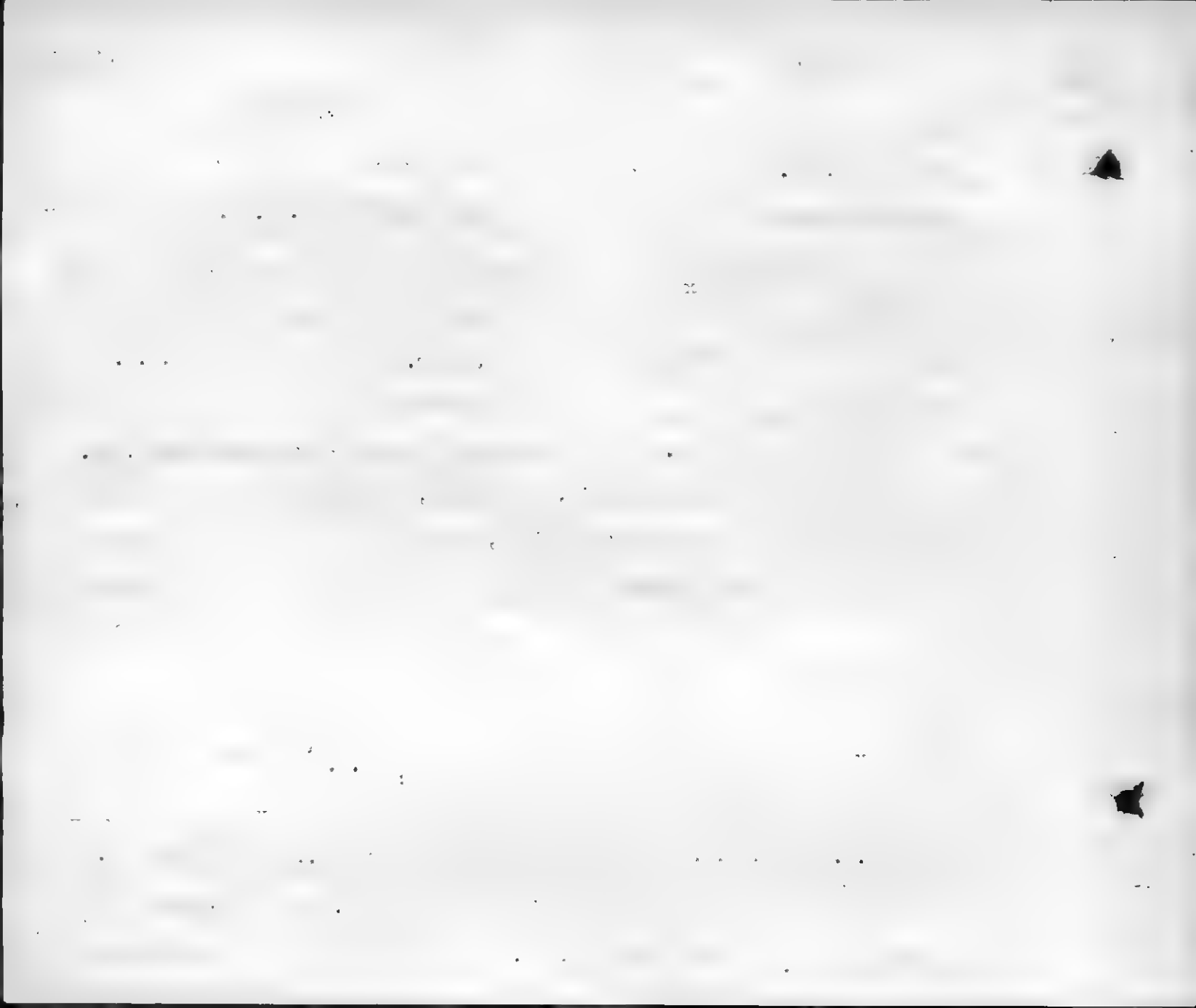


VR A15 (4)
15M 7/61

01789

01772

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Dist of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.		b. COUNTY Washington	
c. LENGTH OF STAY IN 1b 25 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Hospital		d. STREET ADDRESS 1401 Fairmont St. N. W.	
3. NAME OF DECEASED (Type or print) Alex		4. DATE OF DEATH Month Day Year February 11 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 12 29 95		9. AGE (In years last birthday) 66 yrs. 10. IF UNDER 1 YEAR Months Days 1 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Printing	
11. BIRTHPLACE (County & State, or foreign country) Ord. Nebr.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Long		14. MOTHER'S MAIDEN NAME Phoshe Brown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. Unk. 17. INFORMANT VA Hospital Records - VAH Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia, unresolved, bilateral</u> 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Fatty Changes of Liver, severe</u> (c) <u>Malnutrition</u>		INTERVAL BETWEEN ONSET AND DEATH 1 month unknown unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>A.L. MOONEY</u> attended the deceased from <u>1 17</u> 19<u>62</u> to <u>2 11 62</u> 19<u>62</u>, and that death occurred at <u>6:50 a.m.</u> from the causes and on the date stated above.			
22a. SIGNATURE A.L. Mooney		22b. DATE SIGNED 2-11-62	
22c. PHYSICIAN'S NAME (Type) A.L. MOONEY, M.D., Asst Clinical Pathologist, VAH., Perry Point, Md.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/13/62	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Ft. Myer, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE PENNINGTON & SON		25a. REC'D BY REGISTRAR DATE FEB 19 1962	
25b. REGISTRAR'S SIGNATURE C. E. Hume			

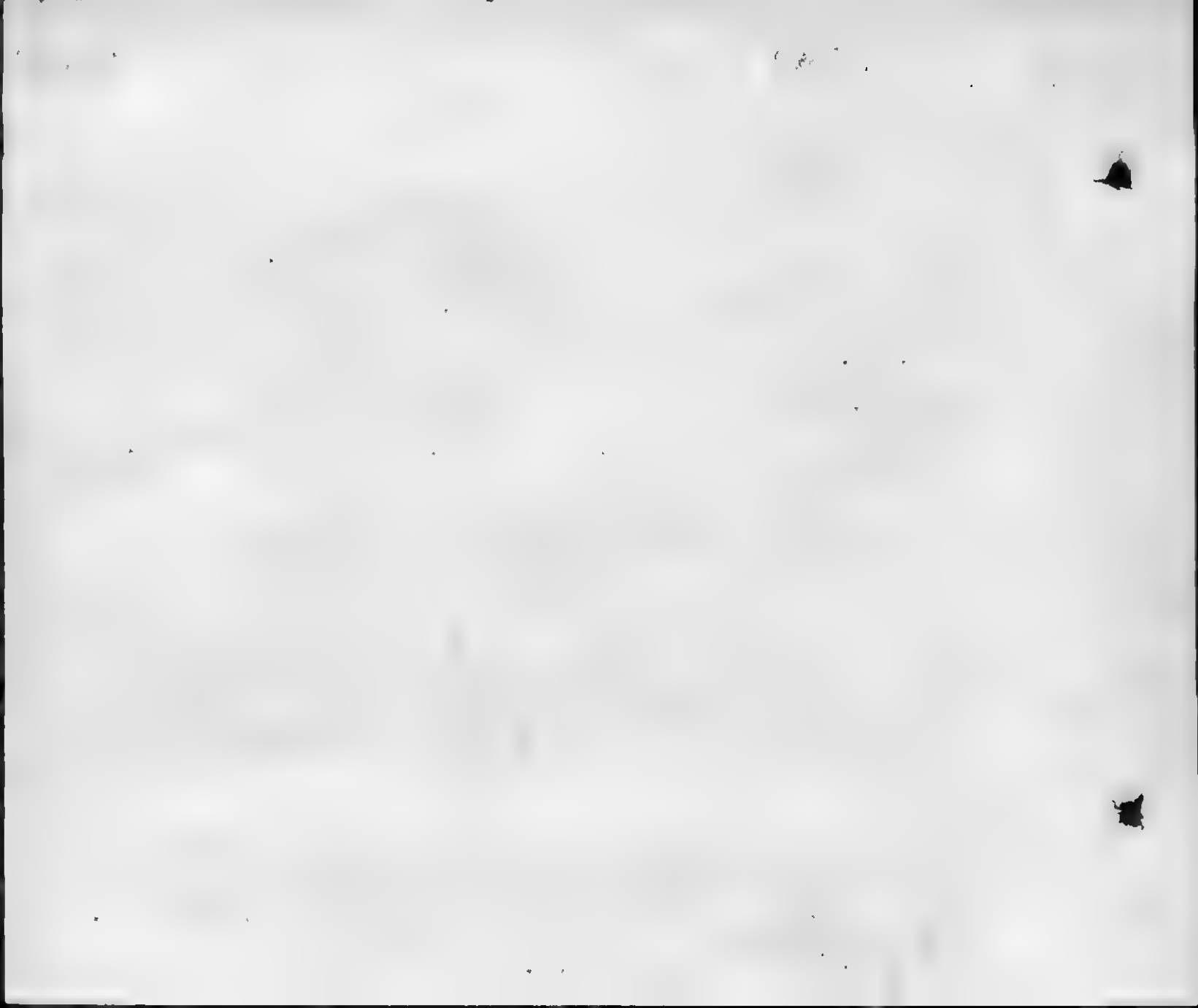


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RECORDS AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01790
CERTIFICATE OF DEATH
01773

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural North East		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural North East	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Lifetime		d. STREET ADDRESS Rural North East	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph R Lynch		4. DATE OF DEATH Month Day Year Feb. 26 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1878
9. AGE (In years last birthday) 83 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Signalman, Penn. Railroad		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James H. Lynch		14. MOTHER'S MAIDEN NAME Rebecca Ella Tyson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 717-07-5304	
17. INFORMANT Marple H. Lynch,		Address Blkton, Maryland.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis Arteriosclerotic Heart Disease DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a), (b), and (c).			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town, (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 19 58 to Feb 26 1962 that (I) (we) last saw the deceased alive on Feb 24 1962, and that death occurred at 5 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Klaus H. Huchner		22b. DATE SIGNED 26 Feb 62	
22c. PHYSICIAN'S NAME (Type) Klaus H. Huchner M.D.		22d. ADDRESS North East, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-1-62	
23c. NAME OF CEMETERY OR CREMATORY Ebenezer Methodist		23d. LOCATION (City, town or county) (State) Rising Sun, Rural Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant		25a. REC'D BY REGISTRAR DATE MAR 2 '62	
		25b. REGISTRAR'S SIGNATURE C. M. S. Evans	



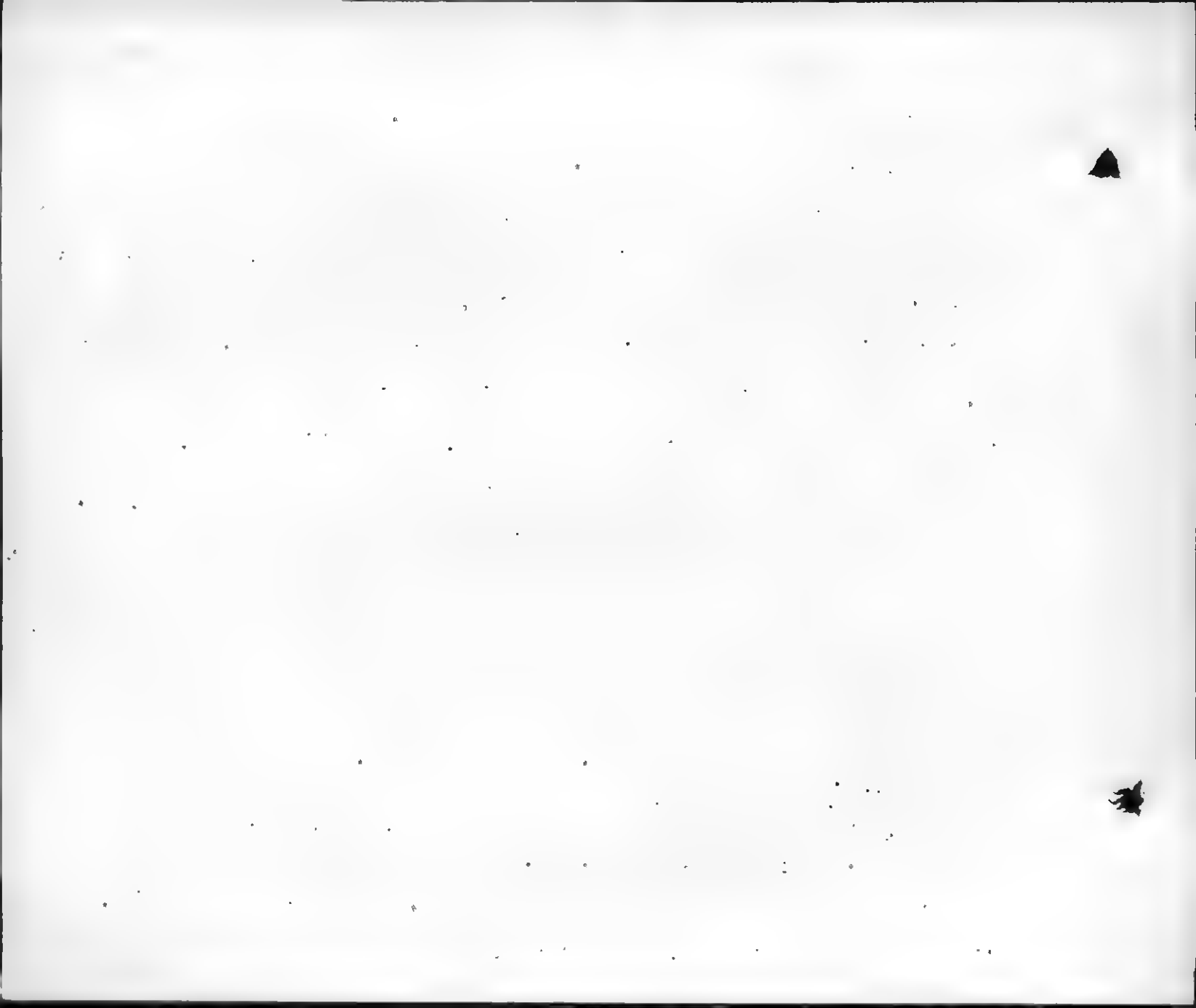
CERTIFICATE OF DEATH

Reg. Dist. No. **01774****01791**

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 70 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 317 Curtis Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AGNES Middle VIOLA Last MOORE		4. DATE OF DEATH Month Feb. Day 10 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 6, 1887
9. AGE (In years last birthday) yrs 75		IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Chesapeake City, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Wm. Washington Montgomery	
14. MOTHER'S MAIDEN NAME Frances Monitor		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. None		INFORMANT Address Arthur R. Moore, Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) Arteriosclerotic cardiovascular disease several yrs DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 hr.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Feb. 4 , 19 62 to Feb. 10 , 19 62 that I last saw the deceased alive on Feb. 9 , 19 62 , and that death occurred at 10:25a from the causes and on the date stated above. ADDRESS (Street, city or town, state) 233 E. Main Street DATE SIGNED 2/10/62	
ACTUAL SIGNATURE [Signature] M.D. 233 E. Main Street		PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D. Elkton Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-13-62	
22c. NAME OF CEMETERY OR CREMATORY Immaculate Conception		22d. LOCATION (City, town, or county) (State) Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Funeral Home		24a. REC'D BY REGISTRAR FEB 14 '62	
24b. REGISTRAR'S SIGNATURE Arthur R. Moore			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01792

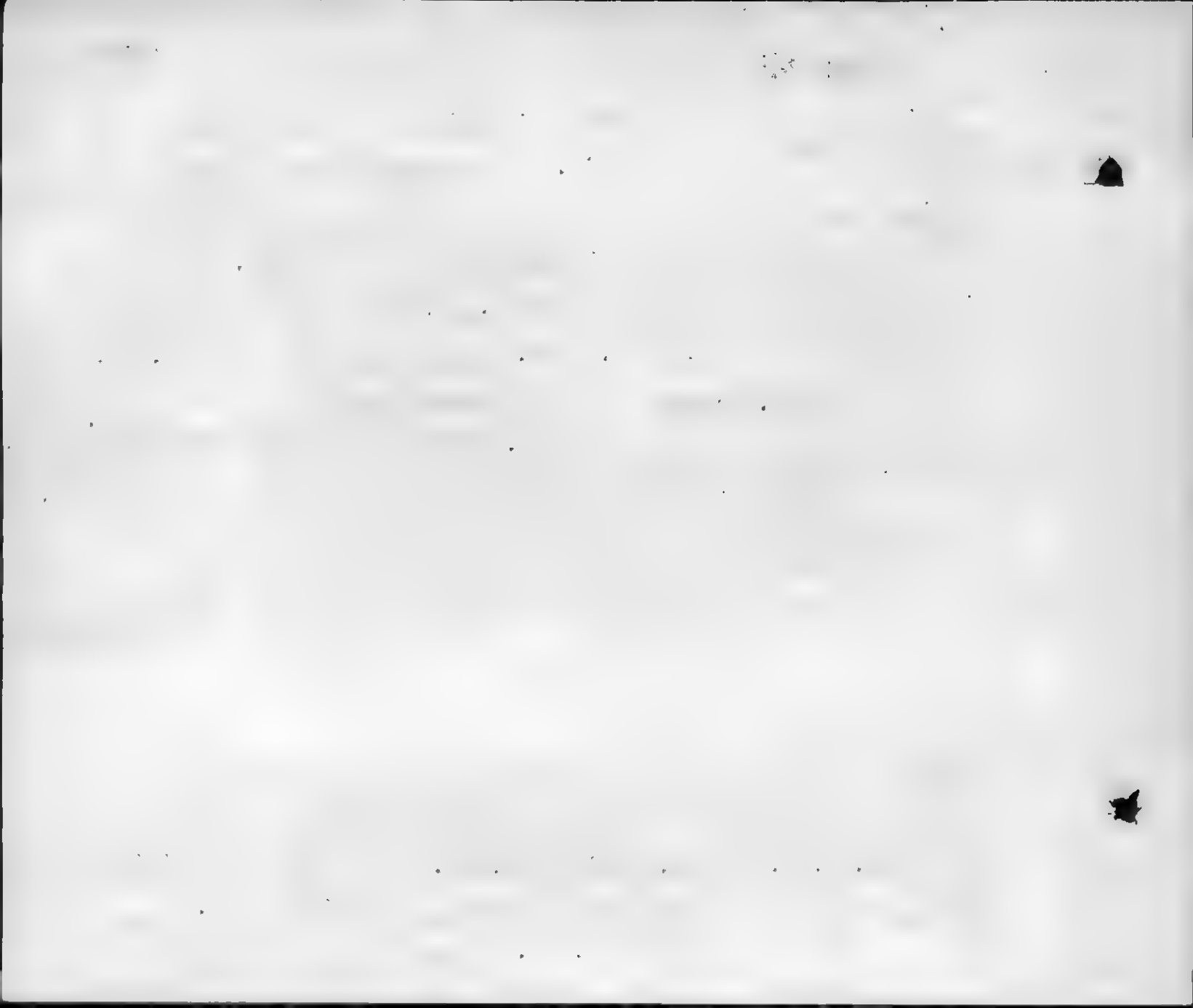
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01775

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN 1b 30 min. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital				2. USUAL RESIDENCE (Where deceased lived, if first put on: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chesapeake City d. STREET ADDRESS <div style="text-align: right;"> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> </div>			
3. NAME OF DECEASED (Type or print) First George Middle Alvin Last Morgan		4. DATE OF DEATH Month Feb. Day 7 Year 1962		5. SEX Male			
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 14, 1894			
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 7 Days 19		11. IF UNDER 24 HRS. Hours 62 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY R. M. R. Corp.		11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George A. Morgan		14. MOTHER'S MAIDEN NAME Hannah Fisher			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give number or date of service)		17. INFORMANT Address Md. Mrs. Georgie S. Morgan, Chesapeake City,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <div style="border: 1px solid black; padding: 5px; margin: 5px;"> Coronary Thrombosis </div> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. </div> <div style="width: 50%;"> DUE TO (b) DUE TO (c) </div> </div> </div> <div style="width: 35%;"> INTERVAL BETWEEN ONSET AND DEATH 30 Min. </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Dr. R. C. Dodson</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/8/62			
EXAMINER'S NAME (Type) Dr. R. C. Dodson, Rising Sun, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/10/62		22c. NAME OF CEMETERY OR CREMATORY Cecilton Cemetery			
22d. LOCATION (City, town, or country) Elkton, Md.		24a. REC'D BY REGISTRAR FEB 20 '62		24b. REGISTRAR'S SIGNATURE <i>C. E. Hines</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



01793

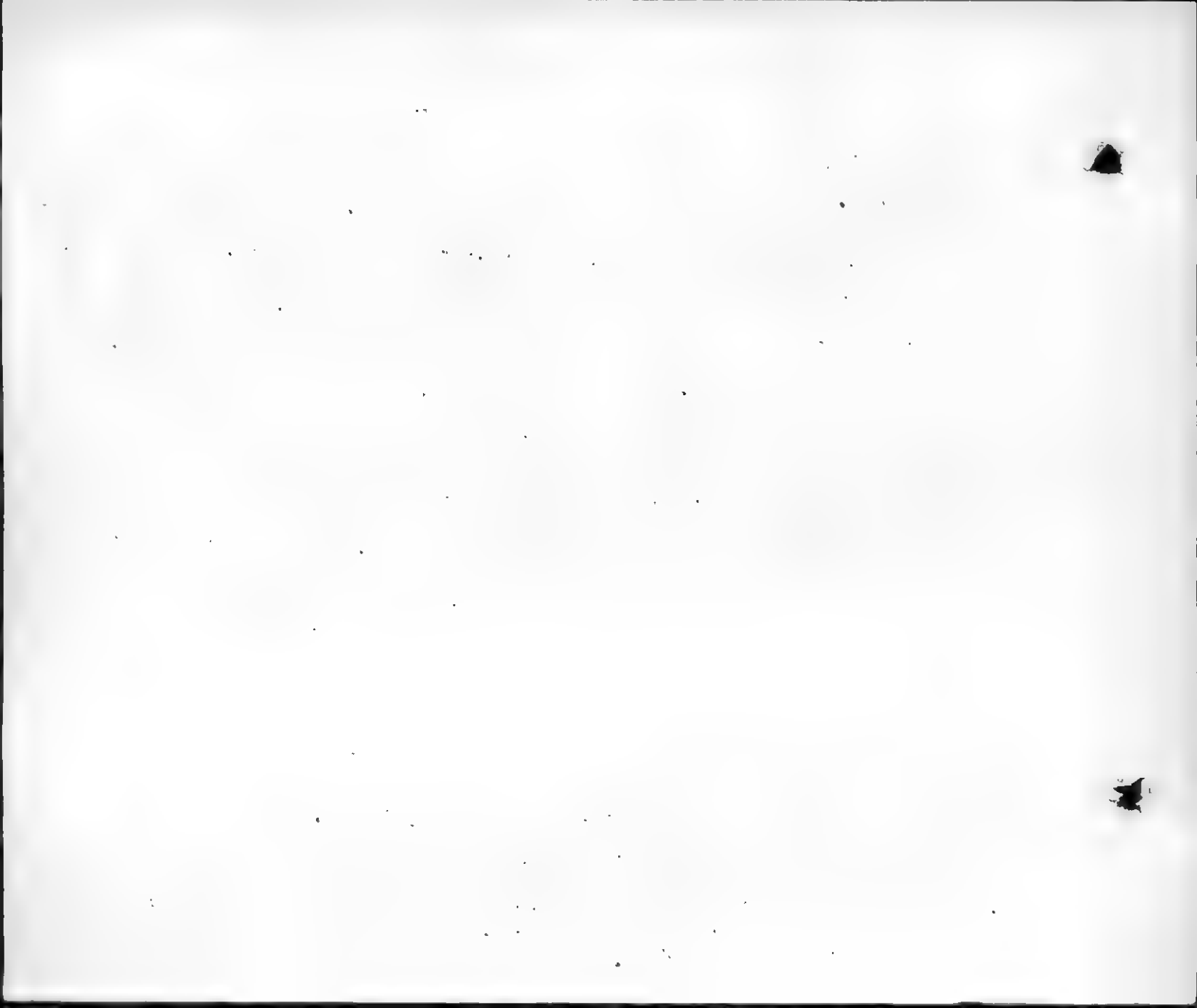
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON	
c. LENGTH OF STAY IN lb LIFE		d. STREET ADDRESS 129 MAFFITT ST.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION UNION HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle M. Last Naylor		4. DATE OF DEATH Month Feb Day 23 Year 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 30, 1889
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 3 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB WILSON		14. MOTHER'S MAIDEN NAME ELIZABETH MOORE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
INFORMANT EDWIN NAYLOR		Address ELKTON, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Embolus 464X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Thrombophlebitis, r.t. Saphenous veins DUE TO (c) 2 weeks			INTERVAL BETWEEN ONSET AND DEATH 25 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease, atrial fibrillation, congestive heart failure			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) failure	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug , 19 60 , to Feb 23 , 19 62 that I last saw the deceased alive on Feb 23 , 19 62 and that death occurred at 4:25 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Tillman D. Johnson		ADDRESS (Street, city or town, state) 123 Sincerly Ave	
PHYSICIAN'S NAME (Type) Tillman D. Johnson M.D.		DATE SIGNED ELKTON, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/26/62	22c. NAME OF CEMETERY OR CREMATORY GILPIN MANOR MEM. PARK	22d. LOCATION (City, town, or county) (State) ELKTON, Md.
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME Donald H. Du		24a. REC'D BY REGISTRAR DATE FEB 26 '62	
ADDRESS ELKTON, Md.		24b. REGISTRAR'S SIGNATURE William S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01794

01777

1. PLACE OF DEATH
a. COUNTY **Cecil** **MARYLAND**
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Port Deposit**
c. LENGTH OF STAY IN 1b **35 Yrs**
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **148 N. Main St.**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE **Maryland** b. COUNTY **Cecil**
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Port Deposit**
d. STREET ADDRESS **148 N. Main St.**
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First **Frances** Middle **Louisa** Last **Paxton**
4. DATE OF DEATH **Feb. 23** 19 **62**
5. SEX **Female** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH **Aug. 24, 1903** 9. AGE (In years last birthday) **58** yrs. IF UNDER 1 YEAR: Months **0** Days **0** IF UNDER 24 HRS.: Hours **0** Min. **0**
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **House Wife** 10b. KIND OF BUSINESS OR INDUSTRY **Own Home** 11. BIRTHPLACE (County & State, or foreign country) **Penna** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **Chester Ironside** 14. MOTHER'S MAIDEN NAME **Unknown**
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No** 16. SOCIAL SECURITY NO. **213-38-9473** 17. INFORMANT **Wesley C. Paxton, Port Deposit, Md.**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **CORONARY OCCLUSION**
4-20-1 DUE TO (b) **ARTERIOSCLEROSIS GENERALIZED**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) **10 yrs**

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year **19** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from **5-20**, 19**60**, to **2-23**, 19**62**, that (I) (we) last saw the deceased alive on **2-31**, 19**62** and that death occurred **4-22** M, from the causes and on the date stated above.

22a. SIGNATURE **G.H. Richards Jr. M.D.** 22b. DATE SIGNED **FEB 27 '62**
22c. PHYSICIAN'S NAME (Type) **G.H. Richards Jr. M.D.** 22d. ADDRESS **Port Deposit, Md.**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE THEREOF **2-26-1962** 23c. NAME OF CEMETERY OR CREMATORY **Hopewell Cemetery** 23d. LOCATION (City, town or county) (State) **Port Deposit, Md. Rural**

24. FUNERAL DIRECTOR'S SIGNATURE **Wm. Patterson, Son** ADDRESS **Perryville, Md.** 25a. REC'D BY REGISTRAR **FEB 27 '62** 25b. REGISTRAR'S SIGNATURE **C. L. S. Hume**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

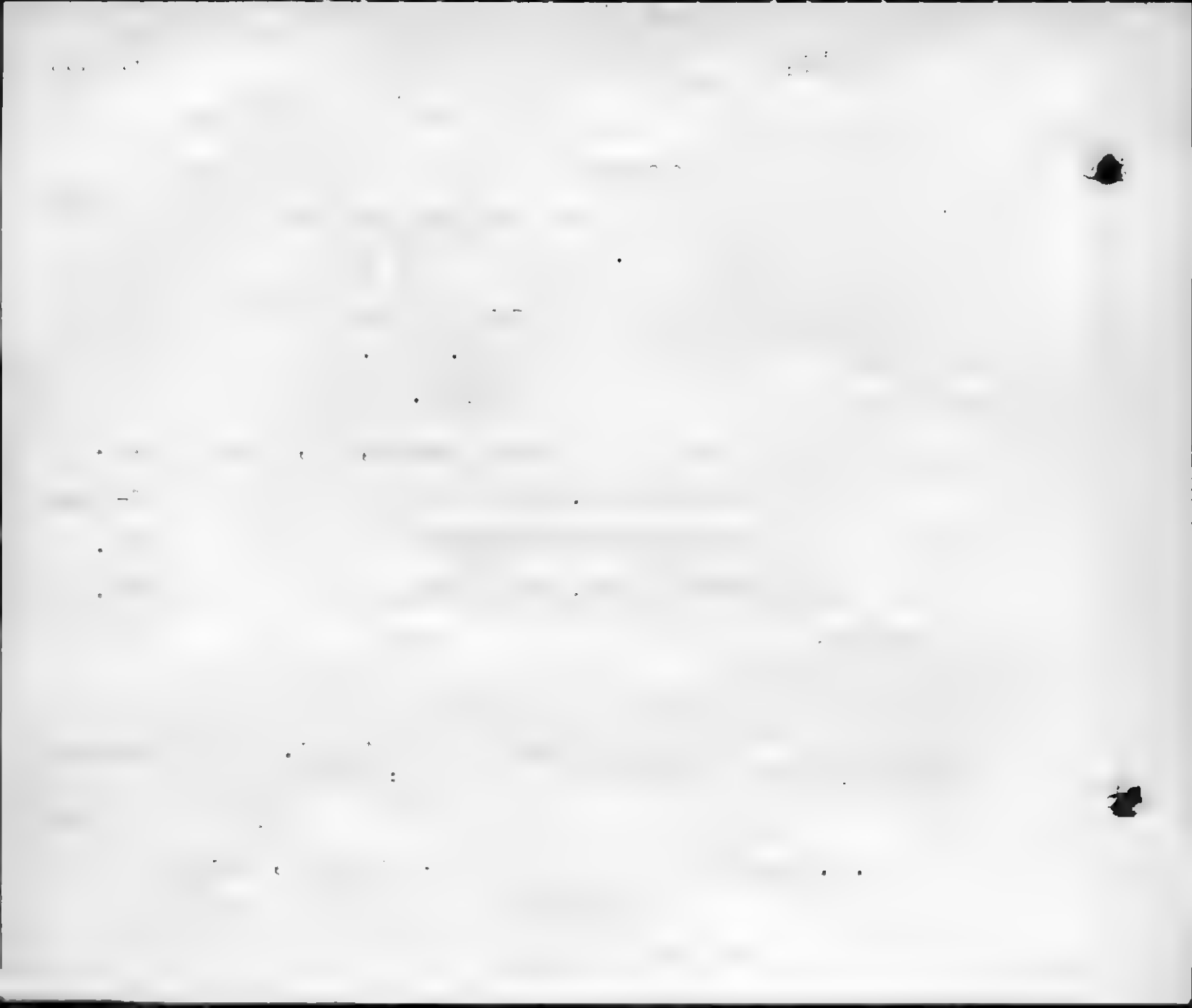
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 213 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Pennsylvania b. COUNTY Philadelphia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia d. STREET ADDRESS 138 Maryland Street	
3. NAME OF DECEASED (Type or print) BENJAMIN W. PEEL		4. DATE OF DEATH 2 3 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-5-80
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (County & State, or foreign country) Phila. Penna.
13. FATHER'S NAME William Peel		14. MOTHER'S MAIDEN NAME Mary E. Moss	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) Yes SAW		16. SOCIAL SECURITY NO. 181 10 4648	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL 42.9 DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE (c) ARTERIOSCLEROSIS, GENERALIZED DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e.g., EMPHYSEMA) INTERVAL BETWEEN ONSET AND DEATH 3-5 Days - Unk. Unk.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from July 5, 1961, to Feb. 3, 1962, and that death occurred at 12:00 Noon on the causes and on the date stated above.			
22a. SIGNATURE A. L. Mooney		22b. DATE 2/3/62	
22c. PHYSICIAN'S NAME (Type) A. L. Mooney		22d. ADDRESS VAH, Perry Point, Maryland	
23a. BURIAL CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 2/4/62	
23c. NAME OF CEMETERY OR CREMATORY Cremation		23d. LOCATION (City, town or county) Philadelphia Pa	
24. FUNERAL DIRECTOR'S SIGNATURE Pennington + Son, Haverhill Mass		25a. REC'D BY REGISTRAR DATE FEB 7 '62	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. Page 5 must be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01796
CERTIFICATE OF DEATH
01780

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CHESAPEAKE CITY</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CHESAPEAKE CITY</u>	
c. LENGTH OF STAY in lb <u>LIFE</u>		d. STREET ADDRESS <u>CHESAPEAKE CITY</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>Jay</u> Middle <u>Sager</u> Last		4. DATE OF DEATH Month <u>Feb</u> Day <u>15</u> Year <u>1962</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 26, 1887</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>JOHN JACOB SAGER</u>		14. MOTHER'S MAIDEN NAME <u>STELLA TRUSS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>FLORENCE M. SAGER</u>		Address <u>CHESAPEAKE CITY, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>4-20-62</u> DUE TO Pulmonary Embolism Acute Congestive Failure Arteriosclerotic Heart Disease DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) INTERVAL BETWEEN ONSET AND DEATH. <u>10 min</u> <u>12 hours</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> a.m. <u>—</u> p.m. 19 <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>15 Feb</u> to <u>15 Feb</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>15 Feb</u> , 19 <u>62</u> and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Wallace Oberstain</u> M.D.		22b. DATE SIGNED <u>15 Feb 62</u>	
22c. PHYSICIAN'S NAME (Type) <u>WALLACE OBERSTAIN</u>		22d. ADDRESS <u>CECILTON, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/19/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BETHEL CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>NR CHESAPEAKE CITY, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME Donald R. Du</u>		25a. REC'D BY REGISTRAR <u>ELTON, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Wm. S. Turner</u>		DATE <u>FEB 20 '62</u>	



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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01797

01781

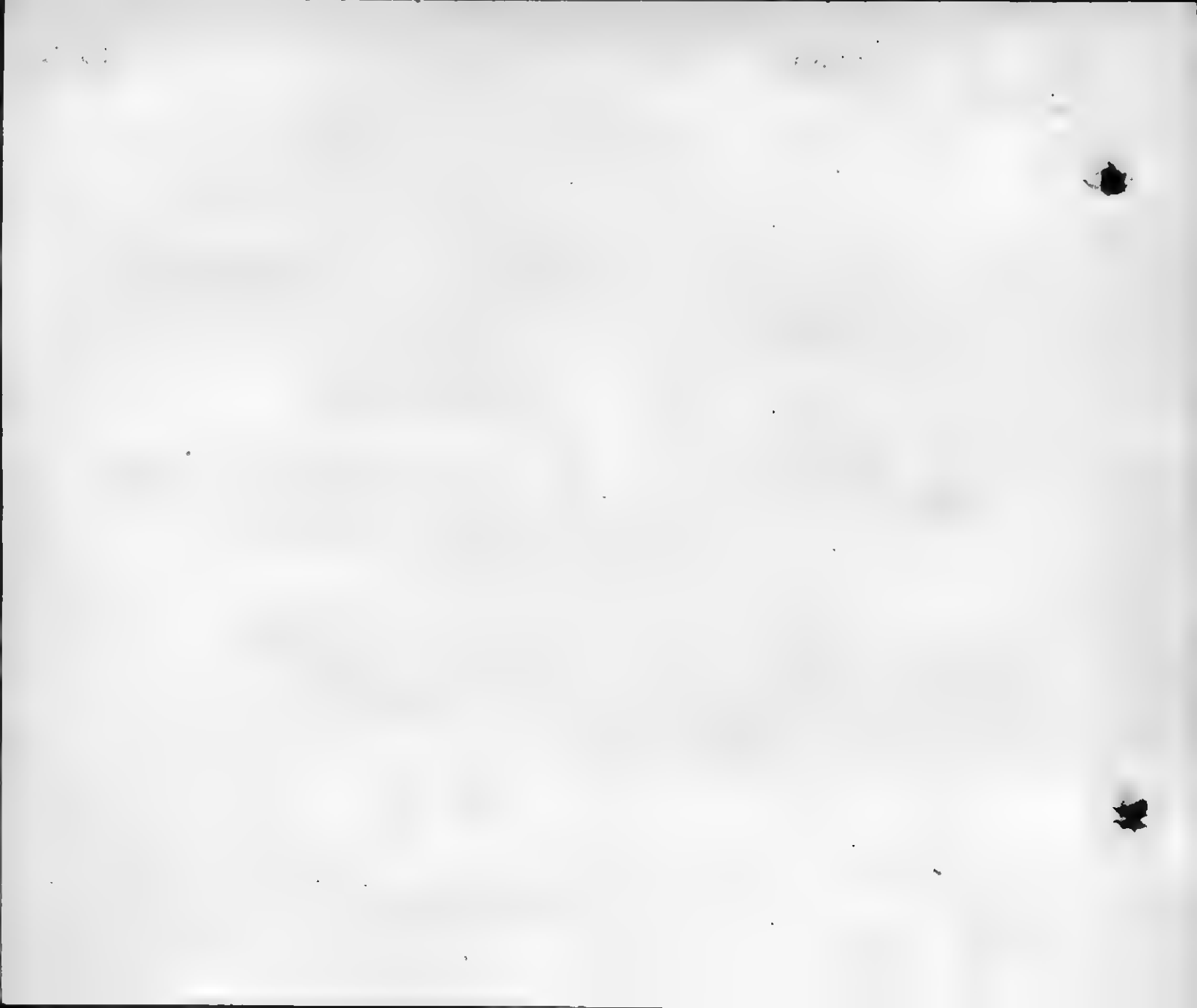
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN IL 8 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlestown d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Roberta E Sapp		4. DATE OF DEATH Month Feb. Day 3 Year 1962	
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 24, 1915 9. AGE (In years last birthday) 46 yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory worker 10b. KIND OF BUSINESS OR INDUSTRY Hosiery & Fireworks 11. BIRTHPLACE (County & State, or foreign country) Cherry Hill, Maryland 12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Maurice E. Egnor 14. MOTHER'S MAIDEN NAME Eva M. Moore		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no 16. SOCIAL SECURITY NO. 212-16-1212 17. INFORMANT Mr. Howard T. Sapp, Charlestown, Maryland. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (a) UREMIA (b) DUE TO HYPERTENSIVE CARDIOVASCULAR DISEASE (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) OBESITY - VIRUS INFECTION - 10 DAYS 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 days 10 YRS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from JAN 26, 1962, to Feb 3, 1962, that (I) (we) last saw the deceased alive on Feb 3, 1962, and that death occurred Feb 3, 1962, from the causes and on the date stated above.	
22a. SIGNATURE Henry V. Davis 22c. PHYSICIAN'S NAME (Type) HENRY V. DAVIS MD 22d. ADDRESS CHEESAPEAKE CITY MD		22b. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 2-7-62 23c. NAME OF CEMETERY OR CREMATORY Rosebank cemetery 23d. LOCATION (City, town or county) Calvert, Cecil Co. Maryland (State)		24. FUNERAL DIRECTOR'S SIGNATURE Joseph H. Grant ADDRESS North East, Md. 25a. REC'D BY REGISTRAR DATE FEB 7 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Harris	



VR AIS (4)
ISM 7/61

01798

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		b. COUNTY Cecil	
c. LENGTH OF STAY IN b. CITY OR TOWN 3 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last ROBERT J. SHANK		Month Day Year February 13, 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 13, 1962	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days	
IF UNDER 24 HRS. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Robert J. Shank	
14. MOTHER'S MAIDEN NAME Marlin Baker		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) None	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Robert J. Shank, Elkton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a), (b), or (c). 35 X DUE TO Respiratory failure due to cerebral ischemia of respiratory center.		INTERVAL BETWEEN ONSET AND DEATH 8 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 13, 1962 to Feb. 13, 1962; that (I) (we) last saw the deceased alive on Feb. 13, 1962, and that death occurred at 4:20 PM, from the causes and on the date stated above.			
22a. SIGNATURE Ralph Andrews, Jr.		22b. DATE SIGNED Feb. 15, 1962	
22c. PHYSICIAN'S NAME (Type) RALPH ANDREWS, JR., M.D.		22d. ADDRESS 2756 Main St., ELKTON, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		25a. REC'D BY REGISTRAR	
25b. REGISTRAR'S SIGNATURE		25c. DATE FEB 15 '62	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
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VR A15 (4)
15M 9/60

1
MARYLAND STATE DEPARTMENT OF HEALTH

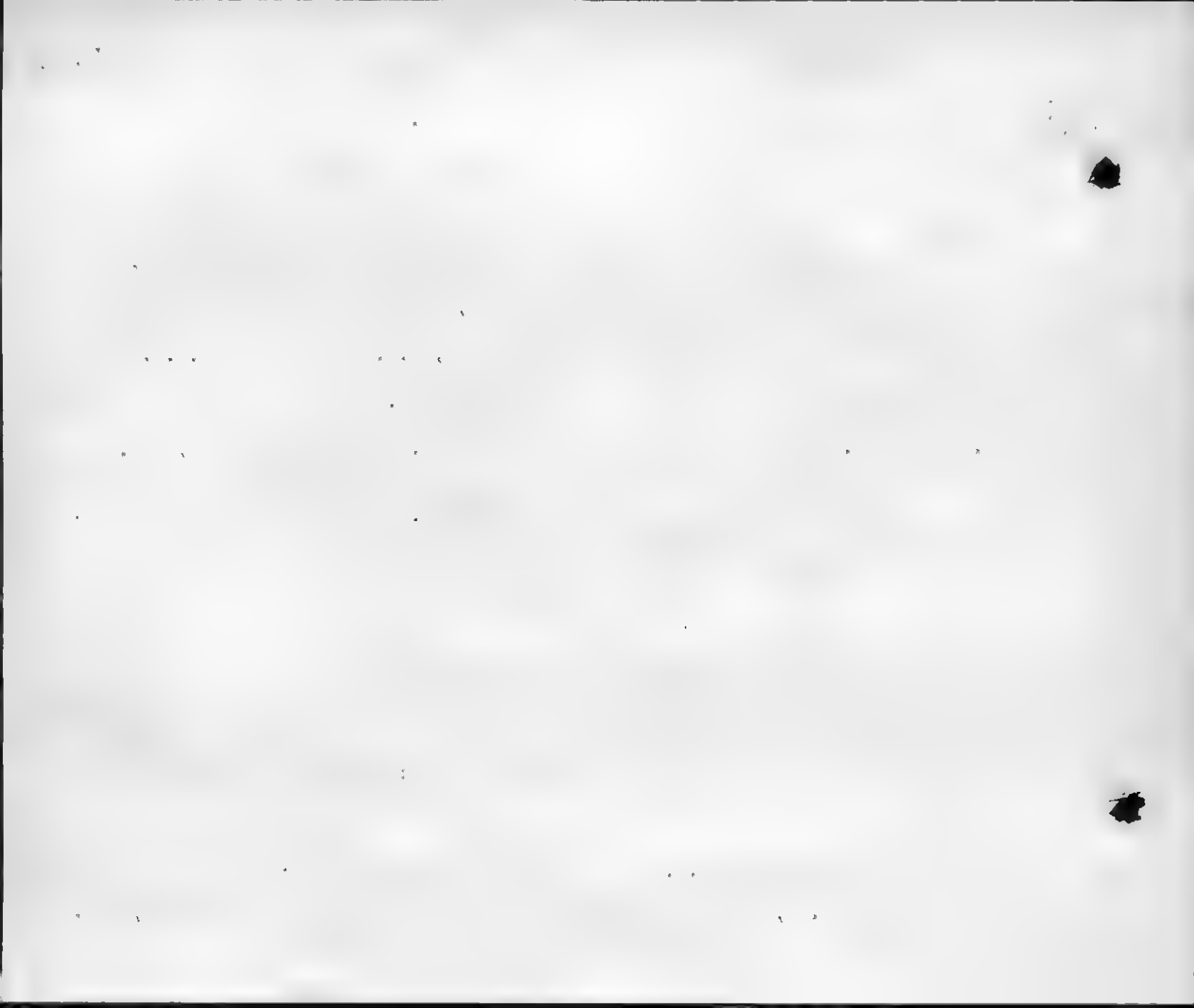
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01799

01783

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Earleville Rural X	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS 	
3. NAME OF DECEASED (Type or print) Ronald Lavern Sheldon		4. DATE OF DEATH Month February Day 11 Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April, 2, 1904
9. AGE (In years last birthday) 57 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Owner	
10b. KIND OF BUSINESS OR INDUSTRY Tavern		11. BIRTHPLACE (County & State, or foreign country) Camden, N.J.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Merritt Sheldon	
14. MOTHER'S MAIDEN NAME Blanch Fix.		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes. W.W. 11	
16. SOCIAL SECURITY NO. 215-18-6311		17. INFORMANT Address Mrs. Thelma E. Brown, Earleville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest due to Massive myocardial infarction due coronary artery disease. DUE TO (b) _____ DUE TO (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Encephalomalacia of right temporal lobe due to old CVA			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 19 1962, to 11 Feb 1962, that (I) (we) last saw the deceased alive on 11 Feb 62 1962, and that death occurred at 3:30 PM from the causes and on the date stated above.			
22a. SIGNATURE Wallace Obenshain		22b. DATE SIGNED 13 Feb 62	
22c. PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D.		22d. ADDRESS Cecilton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 15, 1962	
23c. NAME OF CEMETERY OR CREMATORY Johnstown Cemetery		23d. LOCATION (City, town or county) Earleville, Cecil Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows		25. REC'D BY REGISTRAR FEB 16 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Howe			



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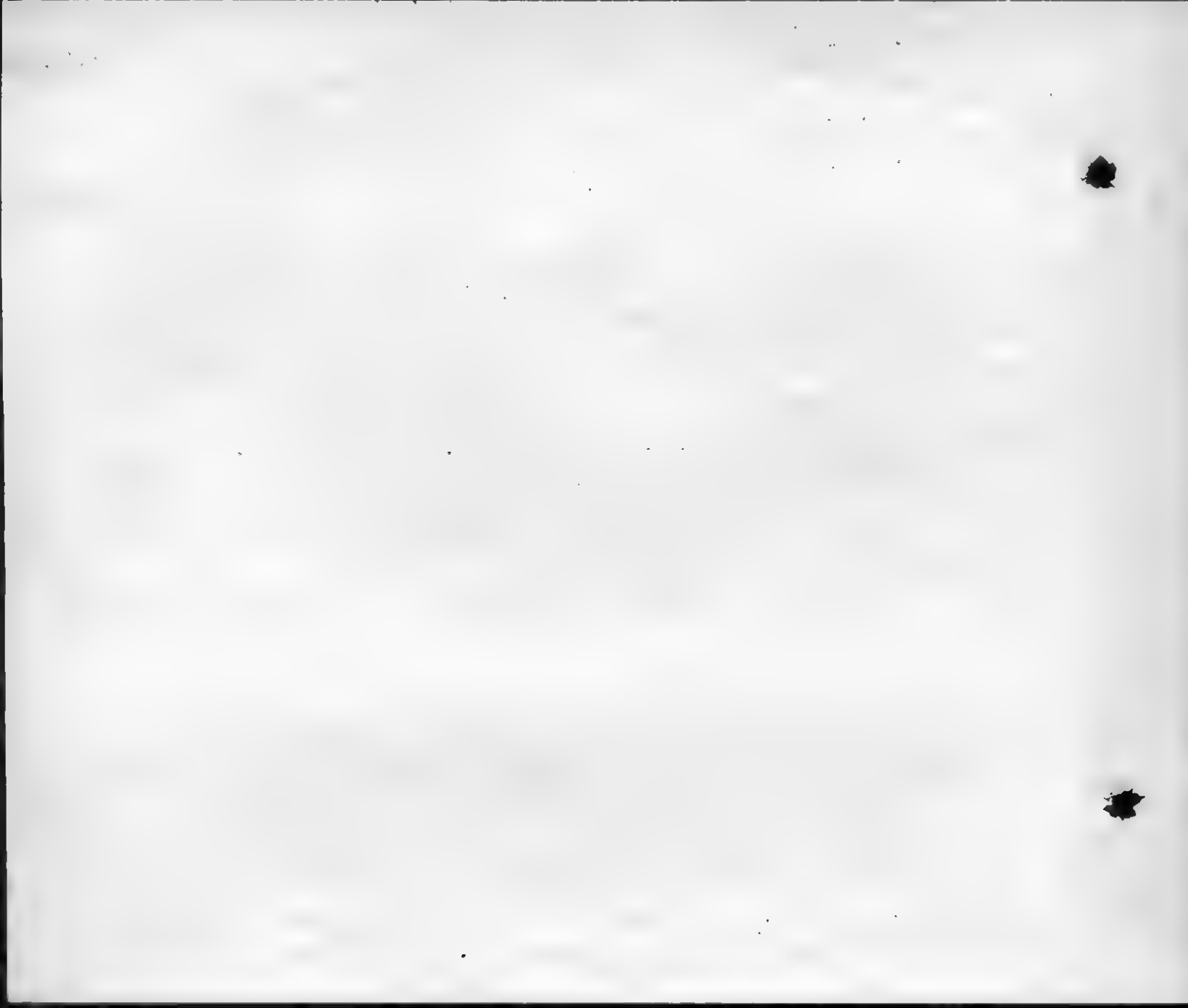
VR A15 (4)
15M 7/61

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01800

01784

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City		c. LENGTH OF STAY IN 1b 55 Yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Chesapeake City	
3. NAME OF DECEASED (Type or print) HELEN CLAYTON STEELE		4. DATE OF DEATH Feb. 6, 1962	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 4, 1877	
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at Home	
11. BIRTHPLACE (County & State, or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joshua Clayton		14. MOTHER'S MAIDEN NAME Levinia Moyer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 213-38-9615	
17. INFORMANT Joseph H. Steele		Address Wilm., Delaware	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (a). Chronic myocarditis DUE TO Chronic hypertensive disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Chronic hypertensive disease		INTERVAL BETWEEN ONSET AND DEATH 16 years	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 18, 1962, to Feb 6, 1962, that (I) (we) last saw the deceased alive on Jan 19, 1962, and that death occurred at 3:41 AM, from the causes and on the date stated above.			
22a. SIGNATURE Henry G. Davis MD		22b. DATE SIGNED Feb 6, 1962	
22c. PHYSICIAN'S NAME (Type) HENRY G. DAVIS MD		22d. ADDRESS CHESAPEAKE CITY MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/8/62	
23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION (City, town or county) (State) Chesapeake City, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph H. Steele		25a. REC'D BY REGISTRAR DATE FEB 9 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			



VR A15 (4)
ISM 7/61



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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01802

01786

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.D.</u> c. LENGTH OF STAY IN 1b <u>3 YRS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RURAL - CONOWINGO, MD.</u>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CECIL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - CONOWINGO, MD. R.D.</u> d. STREET ADDRESS <u>—</u>	
3. NAME OF DECEASED (Type or print) First <u>FRANCE</u> Middle <u>ANNA</u> Last <u>STRONG</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>14</u> Year <u>1962</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG 15, 1900</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SHERIDIAN MORRIS</u>		14. MOTHER'S MAIDEN NAME <u>LYDIA SINGLETON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>RAYMOND A. STRONG, CONOWINGO, MD. R.D.</u>		Address <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>422.1</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Generalized Arteriosclerosis</u> (a) (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>72 HRS.</u> <u>104 HRS.</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>2-11</u>, 19<u>62</u> to <u>2-14</u>, 19<u>62</u> that (I) (we) last saw the deceased alive on <u>2-13</u>, 19<u>62</u>, and that death occurred at <u>8:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>—</u>	
22c. PHYSICIAN'S NAME (Type) <u>—</u>		22d. ADDRESS <u>—</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>FEB. 17, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>DOUBLIN CEM.</u>		23d. LOCATION (City, town or county) (State) <u>HARFORD CO. MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>		24b. ADDRESS <u>Harford Co., Md.</u>	
25a. REC'D BY REGISTRAR <u>—</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneese</u>	
DATE <u>FEB 19 1962</u>		DATE <u>—</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

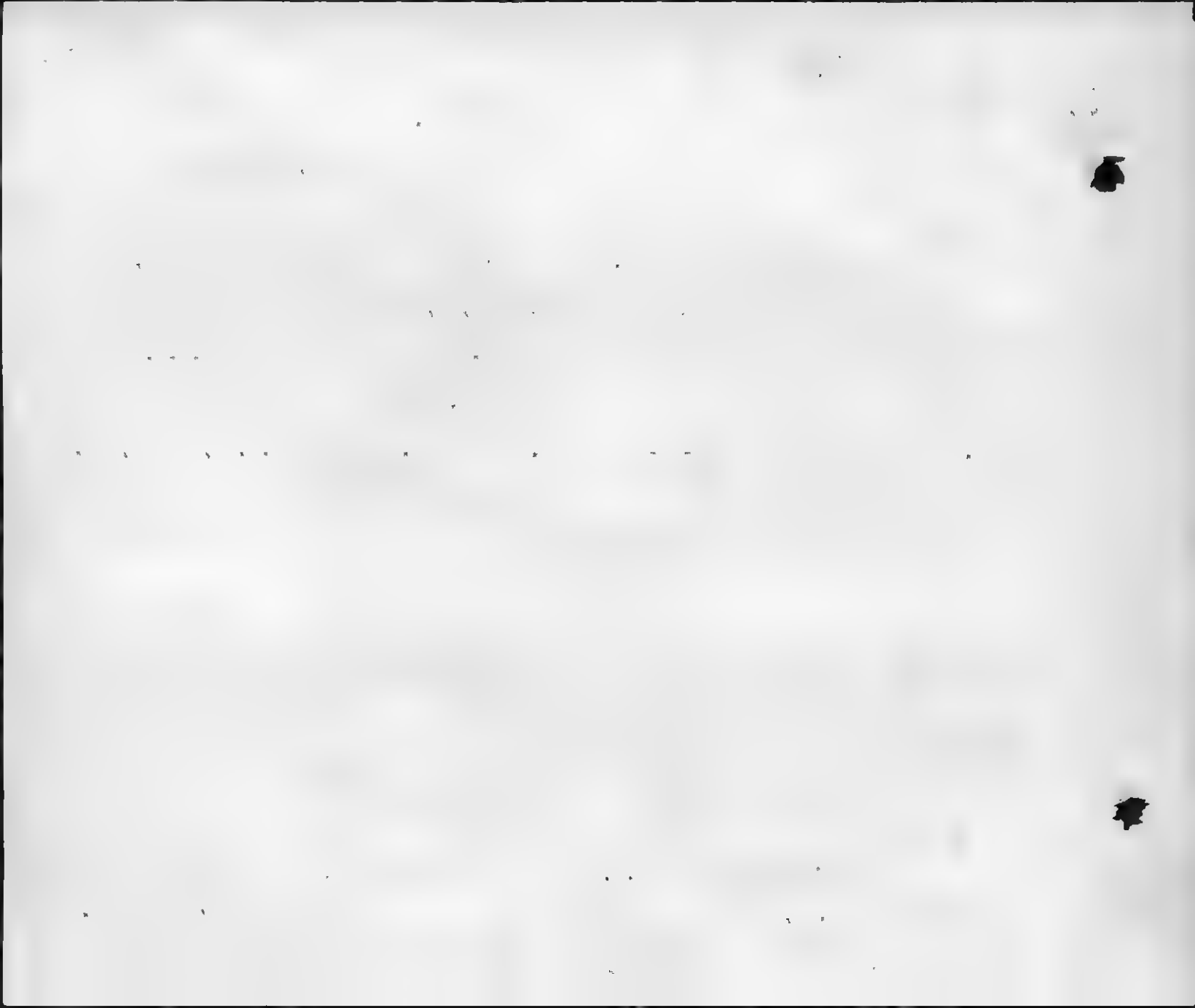
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01803

CERTIFICATE OF DEATH

01787

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN 1b Crystal Beach Manor, Rural Earleville d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crystal Beach Manor, Rural Earleville d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Mary E. White 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH October, 12, 1888 9. AGE (In years IF UNDER 1 YEAR, IF UNDER 24 HRS., last birthday) 73 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework 10b. KIND OF BUSINESS OR INDUSTRY Own Home 11. BIRTHPLACE (County & State or foreign country) Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.			4. DATE OF DEATH February 13, 1962 13. FATHER'S NAME John Weir 14. MOTHER'S MAIDEN NAME Emma W. Boulden 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. 16. SOCIAL SECURITY NO. 218-10-4533 17. INFORMANT Mrs. Lambert B. Manlove, R.D. 35, Media, Pa.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Cecum with metastases to DUE TO (b) right groin Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Jan 15 1961 19 to 13 Feb 62 19 , that (I) (we) last saw the deceased alive on 13 Feb 62 19 , and that death occurred at 8 A M , from the causes and on the date stated above.					
22a. SIGNATURE Wallace Obenchain 22c. PHYSICIAN'S NAME (Type) Wallace Obenchain, M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Cecilton, Md. 22b. DATE SIGNED 15 Feb 62		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Feb. 16, 1962 23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery 23d. LOCATION (City, town or county) Chesapeake City, Md.			24. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Mellington, Md. 25a. REC'D BY REGISTRAR DATE FEB 19 '62 25b. REGISTRAR'S SIGNATURE		



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

FOR STATE
HEALTH DEPT.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01804 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01788											
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural North East c. LENGTH OF STAY IN 1b Lifetime d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) -				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural North East d. STREET ADDRESS - Bay View Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Hannah Mollie Williams				4. DATE OF DEATH February 28 1962							
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 25, 1874		9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Thompson				14. MOTHER'S MAIDEN NAME Annie Tyson							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Mary Williams		Address North East Rd. Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis 4 22.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE R.C. Dodson CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) R.C. Dodson Rising Sun, Md DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) March 2, 1962											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 3, 62		22c. NAME OF CEMETERY OR CREMATORY Bay View Methodist		22d. LOCATION (City, town, or country) (State) North East R.D. Cecil Co., Md					
23. FUNERAL DIRECTOR Joseph R. Grant				ADDRESS North East, Maryland				24a. REC'D BY REGISTRAR 6 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

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1. The first part of the report is a general description of the area. It is a small, flat, open area with a few scattered trees and shrubs. The ground is mostly bare and sandy. The weather is clear and sunny. The temperature is in the 70s. The wind is light and from the west. The humidity is low. The overall impression is of a dry, open landscape.

2. The second part of the report is a detailed description of the vegetation. There are several species of trees and shrubs. The most common are the acacia trees, which are small and have a distinctive shape. There are also some eucalyptus trees, which are taller and have a different shape. The shrubs are mostly low and bushy. The ground is covered with a layer of dry grass and small plants.

3. The third part of the report is a description of the animals. There are several species of birds, including some that are native to the area. There are also some small mammals, such as kangaroos and wallabies. The reptiles and amphibians are not as common. The insects are mostly small and common.

4. The fourth part of the report is a description of the climate. The climate is generally dry and sunny. The temperature is in the 70s. The humidity is low. The wind is light and from the west. The overall impression is of a dry, open landscape.

5. The fifth part of the report is a description of the soil. The soil is mostly sandy and dry. There are some small patches of clay soil. The soil is generally poor and does not support a lot of vegetation.

6. The sixth part of the report is a description of the water. There are no rivers or streams in the area. There are some small ponds and waterholes. The water is generally dry and does not support a lot of life.

7. The seventh part of the report is a description of the people. There are no people living in the area. There are some small settlements and towns. The people are mostly of European descent. The overall impression is of a dry, open landscape.

CERTIFICATE OF DEATH

Reg. Dist. **01789**

01805

1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Pa</i> b. COUNTY <i>Chester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Hancocks Point-Northeast</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Oxford</i>	
c. LENGTH OF STAY IN 1b <i>1 yr</i>		d. STREET ADDRESS <i>51 S. 4th St</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>MARY</i> Middle <i>M</i> Last <i>Wilson</i>		4. DATE OF DEATH Month <i>Feb.</i> Day <i>22</i> Year <i>1962</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 22 1888</i>
9. AGE (In years last birthday) <i>74</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) <i>Homerville Chester Co. Pa</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Joseph Webster</i>		14. MOTHER'S MAIDEN NAME <i>Sophia Zell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT <i>Norman Wilson, 119 Pine St. Oxford Pa</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma of left breast with metastasis</i> DUE TO <i>170X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) — INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) (County) (State) — — —
21. I certify that I attended the deceased from <i>Aug</i> , 19 <i>61</i> , to <i>22 Feb</i> , 19 <i>62</i> , that I last saw the deceased alive on <i>20 Feb</i> , 19 <i>62</i> , and that death occurred at <i>2:15 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>North East, Md</i> DATE SIGNED <i>22 Feb '62</i>			
ACTUAL SIGNATURE <i>Klaus H. Huchner</i>		M.D. <i>Klaus H. Huchner M.D.</i>	
PHYSICIAN'S NAME (Type) <i>Klaus H. Huchner M.D.</i>		—	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Feb. 25, 1962</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Oxford Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Oxford Chester Co Pa</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ralph M. Reed, Rising Sun Md</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 26 '62</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hanes</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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